

WHO global strategy on diet, physical activity
and health:
Western Pacific regional consultation meeting report

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Towards a WHO global strategy on diet, physical activity and health

Background

- 1979 The Global Strategy for Health for All by the year 2000 underlined the growing importance of chronic noncommunicable diseases (NCDs) for developed and developing countries alike.
- 1985 The Thirty-eighth World Health Assembly called for increased efforts to assess the importance of NCDs and to coordinate long-term NCD prevention and control programmes (resolution WHA38.30).
- 1989 The Forty-second World Health Assembly urged the promotion of intersectoral and integrated approaches for the prevention and control of NCDs, especially at the community level in developing countries (resolution WHA42.45).
- 1990 In its report *Diet, nutrition and prevention of noncommunicable diseases*, a WHO Study Group made recommendations to help prevent chronic diseases and reduce their impact (WHO Technical Report Series, No. 797).
- 1992 The FAO/WHO International Conference on Nutrition adopted the *World Declaration on Nutrition* and the *Plan of Action for Nutrition* with the participation of 159 states and the European Economic Community. The Plan of Action for Nutrition promoted 9 strategies for improving nutritional status, one of which addressed the need to promote appropriate diets and healthy lifestyles to prevent NCDs. In the following years the majority of countries prepared and launched national plans of action for nutrition, based on the global plan and its strategies.
- 1997 *The world health report 1997. Conquering suffering, enriching humanity* described the high rates of mortality, morbidity and disability from the major NCDs and proposed the development of a global strategy for NCD prevention and control.
- 1998 Recognizing the burden on public health services resulting from the growth in NCDs, the Fifty-first World Health Assembly requested the Director-General to formulate a global strategy for NCD prevention and control (resolution WHA51.18).
- 2000 The Fifty-third World Health Assembly endorsed the WHO global strategy for NCD prevention and control and urged Member States and WHO to increase efforts to combat NCDs (resolution WHA53.17).
- 2001 A WHO consultation called for urgent action to combat the growing epidemic of obesity, stressing the importance of prevention (*Obesity: preventing and managing the global epidemic. Report of a WHO consultation*. WHO Technical Report Series, No. 894).
- 2001 *Macroeconomics and health: investing in health for economic development*, the final report of the Commission on Macroeconomics and Health, noted that many NCDs can be effectively addressed by relatively low-cost interventions, especially prevention activities related to diet and lifestyle.
- 2002 Having considered a report on diet, physical activity and health, the Fifty-fifth World Health Assembly requested WHO to develop a global strategy on diet, physical activity and health (resolution WHA55.23).
- 2002 "Move for health" was the theme for World Health Day, 7 April 2002. "Move for health" has become a continuing initiative across the world.
- 2002 *The world health report 2002. Reducing risks, promoting healthy life* described how a few major risk factors account for a significant proportion of all deaths and diseases in most countries. For chronic NCDs, some of the most important include tobacco consumption, overweight and obesity, physical inactivity, low fruit and vegetable intake, and alcohol consumption, as well as the risks posed by intermediate outcomes such as hypertension and raised serum cholesterol and glucose levels.
- 2002 A joint FAO/WHO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases examined the latest scientific evidence available and updated recommendations for action (see below, *Phase I*, for details of its report published in 2003).
- 2003 The Framework Convention on Tobacco Control was adopted by the Fifty-sixth World Health Assembly in May 2003 (resolution WHA56.1).

Development of the global strategy

- 2003 **Phase I**
Finalization and dissemination of *Diet, nutrition and the prevention of chronic diseases. Report of a joint FAO/WHO Expert Consultation* (WHO Technical Report Series, No. 916).
- Phase II**
Circulation of a consultation document to guide development of the strategy. Document made public through WHO web-site – January 2003.
Six regional consultations to gather information that will form the basis of the strategy (March–June 2003). Consultations with relevant United Nations and other international organizations, with civil society organizations and with the private sector (May–June 2003).
- Phase III**
Reference Group, a group of internationally recognized experts, to advise WHO on the preparation of a draft global strategy.
Completion of the draft strategy (October 2003).
- 2004 Submission of the draft strategy to the Executive Board at its 113th session (January 2004).
Revision of the draft strategy to take into account the Board's comments.
Discussion of the revised draft strategy at the Fifty-seventh World Health Assembly (May 2004).

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Preface

This report of the consultation in the Western Pacific Region, on the global strategy on diet, physical activity and health, is the last in a series of six. Organized by the Regional Office for the Western Pacific the consultation gave the Member States' perspective on the issues encountered and made specific recommendations on direction, both for the countries of the Region, and for the development of the global strategy. As a whole, the series of reports provides a summarized global account of the status of knowledge about the links between diet, physical activity and health, and the work in countries to address the pandemic of chronic diseases. Added to this will be contributions from consultations with other United Nations organizations, civil society and the private sector. Together these will provide a strong foundation for the development and formulation of the Global Strategy on Diet, Physical Activity and Health and subsequently for action to make measurable changes in diet and physical activity at population level, with positive consequences for the prevention of noncommunicable diseases (NCDs).

As a result of the consultation in the Western Pacific Region, the following key issues were identified and recommendations to address them formulated: development of national policies and plans of action related to diet and physical activity; advocacy for government action and awareness-raising for the public; food regulatory approaches to support the global strategy; creation of environments that promote physical activity; promotion of healthy diets and active lifestyles in specific settings; and the development of plans and processes for a regional NCD network. This report summarizes the discussions at the consultation and outlines the recommendations made.

1. Introduction

Noncommunicable diseases, especially cardiovascular diseases (CVDs), cancers, obesity and type 2 diabetes mellitus, now kill more people every year than any other cause of death. The World Health Organization (WHO) has responded to the global rise in NCDs by giving increasing attention to their prevention and control in recent years (see Box on page 3)

Four factors in the epidemiology of these diseases – poor diet, physical inactivity, tobacco and alcohol use – are of overwhelming importance to public health. Diet and physical activity have recently been the subject of intensified high-level attention by a Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases.¹ The report of the Expert Consultation makes recommendations, inter alia, for optimum nutrition and for worldwide action to stimulate physical activity within a health context. WHO is currently developing a global strategy on diet, physical activity and health to give effect to these and other recommendations.

The Western Pacific regional consultation on the development of the global strategy on diet, physical activity and health was held in Kuala Lumpur, Malaysia, from 7 to 9 June 2003, and was attended by participants and observers from 15 Member States, representatives from the Food and Agriculture Organization of the United Nations (FAO), the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) and the Secretariat of the Pacific Community (SPC), five technical resource persons and WHO regional and headquarters staff (Annex). Participants represented a wide range of sectors including food and nutrition, physical activity, sport, agriculture, health promotion, environment and education. Dr Zainal Ariffin Omar (Malaysia) was elected Chairman, Dr Intan Salleh (Brunei Darussalam) was elected Vice-Chairman, and Dr Colin Tukuitonga (New Zealand) was elected Rapporteur.

Dr Tommaso Cavalli-Sforza, Responsible Officer for the meeting, spoke in welcome to all participants and introduced the programme of the consultation activities for the three days. Dr Kingsley Gee, WHO Representative, Malaysia, speaking on behalf of the Regional Director for the Western Pacific, Dr Shigeru Omi, thanked the Government of Malaysia for hosting the consultation, and greeted all participants. Reviewing the increasing death toll from NCDs and their drain on health resources, he questioned why the risk factors leading to these diseases were growing so fast in the Region. The answers included the many sectors outside health that strongly influence the physical and political environments that determine health, and the consequent need to change values, set up role models for effective communication, support environmental change and strengthen preventive health services. Three high-level meetings had contributed in particular to these conclusions: the Ministerial round table during the fifty-third session of the Regional Committee, the International Conference on Health Conference on Health Promotion (organized by the Japanese Government), in 2002, and the Meeting of Ministers of Health for the Pacific Island Countries, in 2003. Although much had already been accomplished, he identified five areas for further work: the characteristic “short-sightedness” of people, which prevents them from translating their knowledge into healthy behaviours; interaction with the media to achieve mobilization of decision-makers and the public; relationship building with relevant industries that takes sophisticated account of the issues involved; changing emphasis within health systems, routinely using clinical services for health promotion; and managing environment changes in such a way as to mitigate the negative effects of change without losing the positive aspects. Several examples showed that health promotion really worked and that preventive measures, well executed, gave rapid results. Communication, environmental support, and health promotion throughout the life course, involving clinical workers in prevention, would be key strategies.

Dr Biplab K Nandi, Senior Food and Nutrition Officer, FAO Regional Office for Asia and the Pacific, representing the FAO Assistant Director-General and Regional

¹ *Diet, nutrition and the prevention of chronic diseases. Report of a Joint FAO/WHO Expert Consultation.* Geneva, World Health Organization, 2003 (WHO Technical Report Series, No. 916).

Representative for Asia and the Pacific, recalled how the scientific evidence gathered over the last decade had clarified the role of diet in preventing and controlling morbidity and premature mortality from NCDs, with specific components and interventions in that process identified. Factors such as urbanization, diversification of diet through expansion of food availability and supply, and changes in the world food economy all contributed to shifts in dietary patterns. The effect was to support energy-dense diets high in fats, especially saturated fats, and low in unrefined carbohydrates, coupled with a decline in energy expenditure, associated with sedentary lifestyles, and the resulting growth of NCDs seen in the Region. FAO and WHO collaboration had recently included the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases, and widespread advocacy on food-based dietary guidelines. He welcomed the fact that FAO nutrition education tools were increasingly being used and invited further collaboration to apply innovative and successful methods and communication strategies to improve nutritional well being and address NCDs.

Dr Shafie bin Ooyub, Director, Disease Control Division, Ministry of Health Malaysia, spoke on behalf of the Minister of Health, Malaysia, Dato' Chua Jui Meng, to express the Minister's welcome to all participants to the consultation and to Malaysia, to outline the epidemiological situation in the Region as regards NCDs, and the crucial role of dietary measures and physical activity in preventing the spread of chronic diseases such as cardiovascular disease and diabetes mellitus, two of the most significant contributors to mortality in the Region. Referring to Malaysia's own track record since 1991 in promoting healthy lifestyles and establishing an appropriate health infrastructure (the National Coordinating Committee for Food and Nutrition, 1994, a National Plan of Action for Food Safety and Nutrition for Malaysia 1996-2000, and a National Council for Food Safety and Nutrition, 2002), he noted that work was still needed to get the desired effects, and that this would require action by individuals, professionals, communities and governments.

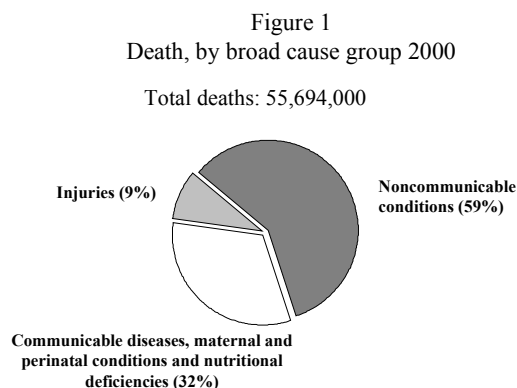
Dr Pekka Puska, Director, Noncommunicable Disease Prevention and Health Promotion at WHO headquarters, describing the process of formulating the strategy, stressed the value of country and regional input and thanked the participants for convening to share their experience.

After a series of presentations by WHO staff and scientific experts (summarized in sections 2 and 3), the participants worked in groups to examine the key issues in relation to diet and nutrition, and to physical activity, and to identify the barriers and obstacles to progress, priority actions and key players in these two areas (section 4). On the basis of the discussions in these groups, the consultation adopted a series of recommendations (section 5).

2. The global perspective

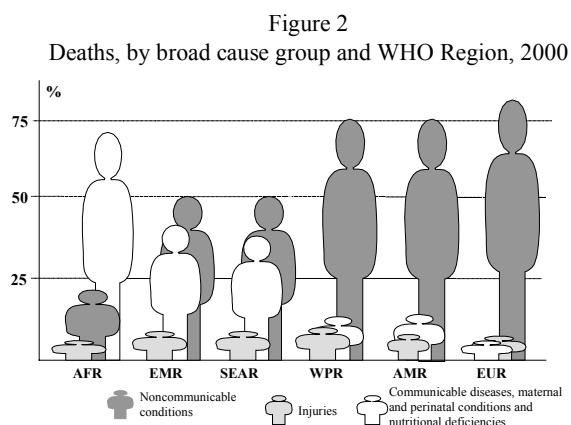
2.1 Health in transition

The world's health is undergoing an unprecedented transition on several fronts: epidemiological, nutritional and demographic. The result, felt keenly at country level and substantiated unequivocally by scientific evidence, is a broad shift in disease burden. The majority of deaths (59%) are from NCDs (Figure 1).



Source: WHO, World Health Report 2001

In the European, American and Western Pacific Regions, NCDs are in an overwhelming majority. The South-East Asia and Eastern Mediterranean Regions are in transition, with NCDs now a more significant public health problem than infectious diseases (Figure 2).



Source: WHO, World Health Report 2001

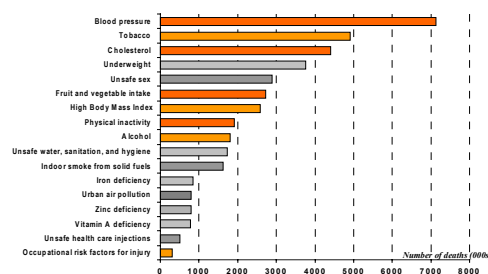
The African Region is also in transition and, while in many countries in the Region communicable diseases still predominate, the incidence of NCDs is rising rapidly.

A wealth of medical research shows the risk factors responsible for this growing pandemic and clearly points out the strategies needed to reduce their impact. The data gathered for *The world health report 2002* show high blood pressure to be the major contributing factor to all deaths in the world (Figure 3).² It is also the leading risk factor in the Western Pacific Region, with deaths due to cerebrovascular stroke particularly high in the

² *The world health report 2002. Reducing risks, promoting healthy life.* World Health Organization, Geneva, Switzerland, 2002.

Region. Of the ten leading risk factors globally, six relate to nutrition, diet and physical activity. In the Western Pacific Region, this amounts to five out of ten. Progress in these two areas, combined with reductions in tobacco and alcohol use, will have enormous importance for the prevention of NCDs and will lead to major health gains that are cost-effective.

Figure 3
Global deaths in 2000 attributable to selected leading risk factors



Source: WHO, World Health Report, 2002

The figures also make clear the important role played by undernutrition. This must not be forgotten in the concern to address overnutrition. In many countries, both forms of malnutrition co-exist. Balanced diet can play an essential role in improving population health. Childhood obesity too is a growing problem across the world, with physical inactivity a major factor.

Close to 80% of the NCD burden is now found in the developing world, moving to lower and lower socioeconomic groups and contributing strongly to inequities in health. The determinants of these changes are urbanization, changes in occupation and many global influences. The transition concerns adults and children alike.

NCDs are to a great extent preventable diseases. While genetic susceptibility to NCDs may be a factor, appropriate preventive action can alter environments, protect against risk factors and change life expectations. On a population scale, relatively modest behavioural changes affecting several of the risk factors simultaneously, can make swift, affordable and dramatic changes in population health.

Diet is a powerful instrument in this regard. In Finland, the North Karelia project reduced annual CHD mortality by 73% over 25 years through community-based activity encouraging a healthier diet. In Japan, reduction of salt intake resulted in lower blood pressure levels and greatly reduced stroke mortality; in Mauritius, changing cooking oil from palm to soy bean oil resulted in a 15% decrease in serum cholesterol in the population; and in Poland, a change in dietary fats resulted in a 20% decline in heart disease mortality.

There are many obstacles to implementing prevention activities, but they can be overcome. They include: outdated concepts such as seeing NCDs as “diseases of affluence”; a lack of understanding about the speed with which prevention activities can make an impact on morbidity; low public visibility for success stories in comparison with the needs of sick patients; powerful commercial interests that block policies and generate conflicting messages; traditional training of health personnel that emphasizes curative care; and inertia among institutions, financing bodies and services.

Food consumption and physical activity patterns are a key to tackling NCDs. However, these behaviours are embedded in the environment, the community, and in areas such as agriculture and food policies. An extensive consultation process has taken place, with Member States throughout the world, and with the wide range of stakeholders involved in the process. In May 2003 the Director-General of WHO held a meeting with high-level private sector representatives, and a second one with nongovernmental organizations (NGOs). In June 2003 WHO met with other United Nations agencies, to raise issues such as increased collaboration, a raised profile for nutrition and physical activity, and research priorities. It will be essential to work with all these sectors, and to look carefully at what factors influence consumption patterns in dialogue with partners and stakeholders. The problems are complex,

and cannot be solved by any one entity on its own. The consultation process for the global strategy will draw all partners and stakeholders into debate, with the specific intention of working positively towards change. WHO is confident that, with this background and through broad consultation, the global strategy will be successfully developed and implemented, leading to major health gains in Member States and globally.

2.2 Physical activity programmes

Physical inactivity is a major risk factor for NCDs, however action to address this is still under-resourced. This is partly attributable to methods of quantifying the risk posed by lack of physical activity, which have led to an underestimation of its real place in the ranking of risk factors for chronic disease and overall health (*The world health report 2002* ranked physical inactivity in sixth place in terms of world attributable mortality in 2000 and in seventh place in terms of the ten leading risk factors as causes of disease burden). This reinforces the need for a global strategy that can coordinate data and action and assert priorities.

Physical activity has both direct and indirect effects on health. It provides independent risk reduction for coronary heart disease (CHD) and stroke; it is as important as obesity in the incidence of diabetes in populations and it is influential on other risk factors that are themselves risk factors for NCDs. In addition to this, it has a moderating effect on the relationship between, for example, obesity and CHD.

A growing multiplicity of physical activity guidelines has caused a degree of public confusion and diluted the messages. The standard recommendation for physical activity to reduce risk is for individuals to accumulate 30 minutes of moderate intensity activity each day.³ Where possible, vigorous activity should also be undertaken. For weight reduction or maintenance, 60–90 minutes of at least moderate activity may be necessary. It is important to be clear that the goal is increased population levels of energy expenditure, and not necessarily improvement of fitness levels.

The “domains” where people expend energy are various: in their leisure time; in organized sport or recreation; in the working environment, in the domestic setting; and in travel/transportation. Experience of which modifiable factors are usually associated with physical activity will be important in planning programmes and strategies. These include: social support for activity, previous adult participation in physical activity; enjoyment of physical activity; and a lower intensity of activity. Examples of factors that have been shown not to be related are equally important, and these include: knowledge about exercise; participation in sports in youth; normative beliefs, and susceptibility to illness. In the same way, shared “best practice” evidence is crucial in planning the most effective way of promoting physical activity. Two areas that have been shown not to work are: worksite programmes, and small group individual change programmes. However, strategies that have worked to some degree are: primary care physicians’ advice and counselling (in the short term); comprehensive multi-strategy school-based programmes, which must include participation by all students; and adequately funded media campaigns. Promising approaches for the future include: changing the physical environment to increase opportunities to be active; changing the social environment to make daily physical activity more important in people’s lives; and integrated, multi-strategy, multi-agency long-term (10–20 year) initiatives.

There is limited data available from the Western Pacific Region on trends in physical activity, however, it appears that there may have been some increase nationally in New Zealand, through the “Push play” initiative, encouraging a minimum of 30 minutes of physical activity, supported by a national awareness-raising campaign. Singapore also has promising early results with its “Trim and fit” campaign, aimed at reducing childhood obesity. There are, however, declines in physical activity levels in Australia. Elsewhere,

³ United States Surgeon General’s Report on Physical Activity and Health, 1996; and *Diet, nutrition and the prevention of chronic disease. Report of a Joint FAO/WHO Expert Consultation*, 2003, op. cit.

countries such as the United States of America do not seem to show any change at all, and only Canada and Finland show increases.

For the future, countries will need to develop national strategies, looking to engineer a culture change to increase total daily physical activity, through innovative approaches, multiple agencies to work on inducing change, and resource commitment. Surveillance through standardized methods and national monitoring will also be key aspects of recording and observing change.

3. The regional perspective

3.1 Dietary guidelines development and utilization in the Region

The *Report of a Joint FAO/WHO Expert Consultation*⁴ identified six strategic actions for promoting healthy diets and physical activity. The second of these was “enabling people to make informed choices and to take effective action”. In this regard, much emphasis has been given to the development of health and nutritional literacy, and dietary guidelines are a key consideration in this effort. Thirty-one countries and areas of the Region completed a questionnaire on the development and utilization of such guidelines.

Of the 71% of countries that have a dietary guideline, 82% have single guidelines, addressing the general public (or in one case, addressing children and mothers). Although all of those guidelines have been promoted and disseminated to a wide variety of audiences and through a range of venues, evaluation has been limited to investigation of specific elements, with overall effectiveness generally not assessed.

Information on the core messages of the guidelines is drawn from the ten sets of country guidelines submitted with the questionnaires. The messages have grown in specificity over the period during which guidelines have been developed (between 1990–2002), even including direction as to the food or food groups to be consumed, and the dietary patterns to be followed. Within a framework of advocating nutritional balance, the guidelines responded to issues both of undernutrition and overnutrition. Core messages included: consuming a variety of foods; eating fruits and vegetables; including sufficient grains/cereals; eating more fibre; including calcium-rich foods and protein-rich foods in the diet; drinking sufficient and clean fluids, restricting the use of fats and oils and being selective about the types of fats used; using less salt (and preferably choosing iodized salt), and eating less-salty foods, cutting down on sugar, and on drinks and foods that contain sugar; encouraging exclusive breastfeeding of babies for six months and continued breastfeeding combined with suitable complementary foods after six months; maintaining a healthy body weight; encouraging physical activity and exercise and suggesting its minimum duration; controlling alcohol intake; and stopping or avoiding tobacco use. Beyond these messages are other important messages on topics such as: assessing daily eating; taking advantage of local dietary culture and local food products; enjoying meals; keeping regular hours for meals; home-growing foods where possible; preparing and storing foods properly; eating clean and safe foods; and taking care with child-feeding, to help children achieve healthy eating habits and support their proper growth.

Concerns raised by Member States focused on assistance with the development, promotion and evaluation of the guidelines. Issues were raised such as whether to promote all of the messages within the guidelines simultaneously or whether to focus on one message at a time. A prominent theme in the comments on evaluation was that there should be a common forum in the Region for sharing experience, in terms of utilization, understanding, and information on whether the guidelines were effective in altering the diets of the populations.

The attention of the participants attending the consultation was drawn to the existence of the WHO/FAO document on the preparation and use of food-based dietary guidelines⁵

⁴ Op. cit.

⁵ *Preparation and use of food-based dietary guidelines*. Report of a Joint FAO/WHO Consultation. Geneva, World Health Organization, 1998 (WHO Technical Report Series, No. 880)

resulting from a consultation. The concerted cooperation of both the agriculture and health ministries in designing and implementing such guidelines is essential coming up with an effective end-product that will address NCDs.

3.2 The regional noncommunicable disease network

The mandate for action on NCDs is already firmly in place in the Western Pacific Region, through such policy statements as the Pacific Island Countries' "Call for Action on Obesity" in 2000, and the Madang Commitment in 2001, the Western Pacific Declaration on Diabetes in 2000 and the Tonga Commitment in 2003 to a "STEPwise Framework for NCD Intervention". Strong surveillance is already in place through the STEPS programme, national NCD plans are either under development or already in place in several countries, obesity prevention and control projects have been supported by WHO in two Pacific Island countries, with more to follow, and clinical management guidelines are being developed and implemented in several countries in the Region, with the challenge foreseen for the future of developing evidence-based algorithmic guidelines appropriate for the resource base. Through these activities, and many more, a considerable body of experience is already building in the Region, which will support the implementation of the global strategy on diet, physical activity and health, and complement the work proposed for the regional NCD network — proposed to be called MOANA (Mobilisation Of Allies in NCD Action).

International experience of the success of networks in other regions such as CINDI (the Countrywide Integrated Noncommunicable Diseases Intervention, in the European Region and the CARMEN project (*Conjunto de Acciones para la Reducción Multifactorial de las Enfermedades No Transmisibles*; actions for the multifactorial reduction of noncommunicable diseases), in the Region of the Americas, provides a useful basis for the development of a similar process in the Western Pacific Region, as mandated by the Regional Committee for the Western Pacific in 2000 (Resolution **WPR/RC51.R5**), and further developed by numerous meetings, round tables and declarations on the area of NCD prevention. The Global Forum, which fosters regional and national networks, also provides a possible template. The Forum disseminates evidence and guidance on primary and secondary NCD prevention, supports advocacy for increased NCD awareness, harmonizes surveillance methods, and promotes and contributes to collaborative research and capacity-building, especially in developing countries.

There are several key concepts behind these international NCD networks, on which the Western Pacific Region's proposed network would draw:

- First, the national NCD policy and demonstration areas: these have been a central aspect of the CINDI country programmes. They test intervention approaches, raise public awareness of prevention, produce models for extension to other parts of the country, work as a powerful tool for the development of national health policy, and provide opportunities to build skills.
- The second concept is of integrated, intersectoral, community-based action. These facets are well demonstrated by the CARMEN project, which crucially does not work on a vertical programme structure but recognizes the linkages between the intermediate risk factors and the ultimate determinants of NCDs, taking approaches that focus on populations and high-risk groups. Action is across all governmental and nongovernmental partners, with close international collaboration with CINDI.
- The third element is the specific commitment of resources and the establishment of a structure by the governments that apply for membership in the network.
- Fourth: there are agreed common surveillance and evaluation protocols across the networks, with centralized data management (as in CINDI) and external review, to chart the progress of the project.

- Fifth: there is country autonomy in the selection of priorities and specific programmes, to ensure that they are appropriate and consistent.
- Sixth: linkages with other networks such as healthy settings (Healthy Cities, Safe Communities etc) provide mutual extension of scope, underscore the health services contribution to community action (for example against risk factors such as hypertension), emphasize formal project planning within the national policy, and provide a theoretical approach to evaluation and monitoring.
- Lastly, formal dissemination processes are a key concept. These include regular meetings, telephone conferences, newsletters, electronic links, strategic position papers, training workshops, a pool of institutions, experts, and short-term consultants that can provide expertise; a directory of planned and ongoing community-based activities and short-term working groups on specific areas identified by the forum or network.

4. Regional issues raised by the working groups

The following issues are drawn from the collective experience of the Member States.

Through small group meetings, a synthesis of points was drawn from country experiences with a view to establishing what were the successes, challenges, and lessons learnt from national efforts to promote a healthy diet and active lifestyle.

Australia, Japan, the Republic of Korea and New Zealand described successes such as: the regularly gathered national data sets through which progress could be measured; national health regulatory and legislative mandates; comprehensive long-term health promotion programmes; the targeting of disadvantaged populations; integration across sectors; political mobilization; and an appropriate mix of culturally specific messages and programmes (in New Zealand). Challenges included: the need for long-term commitment; complex political structures and cycles; high prevalences of NCDs with risk factors increasing; the erosion of traditional diets; the need to engage with the private sector; and increasing prevalences of underweight among young females (in Japan). Lessons learnt included: the development of appropriate industry relationships, producing clear health benefits; improvements in marketing messages and in working across government and with NGOs; increased equity focus; the need to undertake health impact assessment of new policies, and to establish creative legislative mandates wherever possible.

China, Malaysia, Mongolia and French Polynesia reported successes in achieving high-level political commitment; intersectoral collaboration, with the development of national plans and strategies; the promulgation of legislation, regulation and codes, for example on labelling of nutritional content; active NGOs; and mass organized communication strategies, such as healthy lifestyle campaigns. The challenges discussed included: achieving intersectoral collaboration at national level; decentralization of public investment; the perception that NCDs are non-urgent matters; insufficient capacity in intervention and social mobilization; legislation; and monitoring and evaluation. The lessons learnt were: how media advocacy can be used to change public policy; the need to promote correct and responsible advertisements; the value of partnership with the media; the need for a multi-strategy approach in social marketing; the utility of the healthy settings approach; the importance of supportive environments for physical activities; and the need for continued monitoring and evaluation.

Cook Islands, Fiji, Kiribati, and Tonga described their successes as including: the development of NCD prevention and management guidelines; collaboration with a variety of stakeholders; budget allocation for preventive activities; strong “Healthy Island” projects; strong national nutrition committees; a range of supportive policies and legislation; increased awareness about the role of physical activity in health; increased acceptability of culturally

appropriate exercise (in Tonga) and, in Kiribati, where previously, in the tradition of gift-giving, tobacco was given as a present, this has changed to gifts of sports equipment instead. The challenges include: lack of human resources, budget and data; obstructive local cultural beliefs and policies; political instability; expensive media; a poor natural environment; the high cost of healthy food; and industry sponsorship, which has moved from the tobacco industry to the food industry. The lessons learnt include: the need to plan in sustainability from the start of projects and involve the community in planning and implementation; the requirement for a strong national coordinating body and an active focal NCD point; the utility of proactive work with the food industry; the value of relationship building with the media; ways of strengthening surveillance programmes; supporting consumer and community voices; how to extend health-promoting settings through other activities; the need to seek high-level commitment and supportive legislation; tailor activities to the local environment; and using local plans to seek funding from donors.

Brunei Darussalam, the Philippines, Singapore and Viet Nam described their successes as including: the establishment of some form of national public health development plan or national nutrition plan; these set the stage for healthy lifestyle campaigns and provided mechanisms for intersectoral collaboration; establishment of high-profile role models, such as the Sultan of Brunei; the surveillance and assessment of risk factors; raising of awareness; schools programmes; participation (in Singapore) in the “healthy choice” programme, for example, adherence by companies to “healthy choice” labelling. Challenges included: the need for the global strategy to take into account the differing levels of development among countries; the variety of experience available in monitoring and evaluating interventions; the need for trained human resources; the strategies to control a double burden of overnutrition and undernutrition; the need to ensure food safety in the context of overuse of pesticides and chemical fertilisers; the difficulties of sustaining awareness and translating it into practice; the need to identify clear roles for stakeholders in an intersectoral process; the issue of conflict of interest in the context, for example, of sponsorship; the difficulties in enforcement of legislation or codes of practice; the sustained involvement of local government; the achievement of balance in the relationship with food producers (no “endorsement”). General considerations were outlined: despite low awareness, micronutrient fortified foods were consumed (in the Philippines) because of competitive pricing and appropriate selection of products. Culture and gender-sensitive programmes (in Viet Nam) promote the life of communities, and (in Brunei) traditional recipes, dances, and martial arts are adapted. National and international strategies need to take into account the locally produced and fresh foods available from the strong agricultural basis of most of the cultures of the Region.

5. Conclusions and recommendations

5.1 Conclusions

1. The summary of ideas and experiences discussed at the Ministerial round table during the fifty-third session of the Regional Committee for the Western Pacific in 2002 together with its recommendations, forms a useful contribution to the development of the global strategy on diet, physical activity and health.⁶
2. Through the Ministerial round table meeting, and several other important high-level meetings in the Region, there is increased awareness among decision-makers of the importance of the NCD issue and motivation to make progress in developing the global strategy and the tools and processes through which to implement it.

⁶ *Ministerial round table on diet, physical activity and health, Regional Committee for the Western Pacific*. Fifty-third session, 16–20 September 2002, World Health Organization, 2003.

3. Promotion of a healthy diet and active lifestyle can be effectively accomplished through a “settings” approach, interpreted as places where people work and study, play and socialize.
4. It is vital that all initiatives are well supported by media, social marketing and promotion exercises that are well planned, executed, and adequately funded.
5. Although good work is ongoing in systematic collection of data in the Region, there is a need to overcome obstacles such as the lack of food consumption and physical activity data in countries and to assemble regional databases in conjunction with important partners such as FAO.
6. Country studies on determinants of dietary patterns and lifestyles are needed as a basis for designing effective health promotion campaigns.
7. Planning and implementation of interventions to promote healthy diets and physical activity should be targeted especially to sectors of the population with the highest risk of nutrition-related NCDs, including the poor and minority groups, where relevant.

5.2 Recommendations

The following six areas were those considered to be particularly important for the development and implementation of the global strategy.

Development of national policies and plans of action related to diet and physical activity

To Member States

1. Determine the planning approach most relevant to country situation/needs, reviewing the existing plans and establishing what else is needed, and determining the appropriate time-frame and what resources can be committed.
2. Develop the national plan for healthy diet and physical activity, by building on, or integrating with the National plan of action for nutrition (NPAN), with vertical non-communicable disease plans, and with existing agriculture or national development plans, in conjunction with the relevant departments of education, transport, social security etc.
3. Ensure that elements such as the promotion of infant and young child feeding practices and action to combat micronutrient deficiency through food fortification are sensitively integrated with proposed action to combat overnutrition, and that nutrition messages in those and other respects are consistent.
4. Ensure that the departments of sport and recreation commit to healthy physical activity as well as to organized sport.
5. Commit to the process, and ensure that it has a champion in government, preferably the leading decision-maker, as well as champions in other sectors.
6. Assure implementation through “joined up” national, regional, and local planning, good communication with agreed focus, definitions etc, committed funding from both private and public sectors, and resources in place such as workforce, training, legislative support and research.

To WHO

1. Develop a policy and plan of action template.
2. Provide support, through technical papers from WHO and other agencies such as FAO, for example on intersectoral action on nutrition and physical activity, or economic analyses of benefits.
3. Provide advocacy support, using resources such as governing bodies and expertise of partner agencies.
4. Facilitate the sharing of experience and technical evidence.

5. Give “on-the-ground” advice and support during implementation.
6. Support the development, utilization, evaluation and review of national food-based dietary guidelines and national guidelines for physical activity.
7. For the draft strategy to be considered as an intersectoral endeavor, it should be discussed not only in the Ministry of Health, but also at Cabinet level, to obtain cross-sectoral commitment by countries.

Advocacy for government action and awareness-raising for the public (media and other channels)

To Member States

1. Develop an advocacy plan based on evidence from established monitoring and surveillance systems and other data streams.
2. Use evidence of achievements in reducing disease rates and savings achievable by cutting health costs to persuade politicians to put health high on their agenda.
3. Use creative and relevant communication strategies to impart awareness of the issues to policy-makers in both the health and non-health sector, and to increase public awareness of nutrition and physical activity.
4. Identify and support champions who are committed to the goals, objectives and implementation of national strategies on nutrition, physical activity and health.
5. Integrate health promotion initiatives into health and non-health settings, such as the community, markets, schools and workplaces.
6. Provide incentives such as awards and prizes for excellent health promotion programmes and initiatives
7. Promote consumer education about food labelling and product information to support healthy choices.
8. Promote pro-health legislation that rewards people for maintaining wellness.
9. Promote and popularize, through education for the general population, using mass media, traditional healthy cooking techniques with healthy ingredients as alternatives.
10. Promote physical fitness campaigns for the general population using traditional dances and martial arts as popular vehicles.
11. Seek links with programmes like tobacco control and prevention of alcohol abuse, and mutually strengthen promotional activities such as promoting tobacco-free sports while promoting fitness and healthy diets.

To WHO

1. Provide technical or documentary support to the efforts of countries to address the various targets of advocacy: policy and practices, laws, marketing practices, and other health promotion, sharing “best practices” from the experiences of other countries.

Food regulatory approach to support the global strategy

To Member States

1. Strengthen food labelling legislation to incorporate health promotion objectives and nutrition concerns, thus making it easier to have healthy diets.
2. Make health impact assessment an integral requirement of all relevant legislative decision-making processes.
3. Mandate the inclusion of a nutrition information panel on all packaged food.
4. Consider approaches to encourage nutrition information at point-of-sale for non-packaged food, for example, the fat content of fresh meat.
5. Consider the optimal regulatory approach to restrict food manufacturers’ sponsorship arrangements in schools.

6. Consider optimal regulatory (for example, a code of practice) arrangements for restricting marketing of foods and drinks containing high levels of fat, sugar, salt, especially to children including television advertising, sports and concerts sponsorships and point-of-sale promotions etc.
7. Review the potential commitments represented by membership of the World Trade Organization (WTO) to reduction of tariffs and domestic subsidies on food and agriculture.
8. Promote the availability of healthy food in school canteens in line with the joint WHO/FAO report of the expert consultation on diet, nutrition and the prevention of chronic diseases.
9. Restrict, through appropriate legislation, the availability in schools of food and drinks containing high levels of fat, salt and sugar, including the presence of machines vending such foods and drinks.
10. Consider the imposition of targeted taxation on certain foods and drinks containing high levels of fat, salt and sugar, and incentives for the production and sale of healthier foods.

To WHO

1. Provide technical support to review the current legislation and assess the health impact of the development of food regulatory approaches.
2. Provide support to individual countries to develop the case for mandating a nutrition information panel on food and drink packaging.
3. Explore the barriers to global harmonizing of food labelling, in collaboration with FAO.
4. Promote research into the effectiveness of food labelling in terms of its benefits to health and make this information available to Codex through the appropriate committees.
5. Provide, within the framework of the WHO/FAO Codex Alimentarius, advice to countries on best practices for the introduction of effective food labelling.
6. Identify and help to choose optional approaches to the control of food marketing and advise Member States.
7. Provide technical expertise to support the health department in regard to trade negotiations and implications for health of trade-related issues.
8. Provide technical expertise to support the health department in developing appropriate regulatory approaches to food availability and accessibility issues.
9. Provide technical guidance in the establishment and application of criteria for defining high, medium and low content of fat, sugar and salt in food, based on internationally agreed guidelines and on the levels of consumption of different foods in countries.

Creating environments that promote physical activity

To Member States

1. Develop a comprehensive national policy on physical activity that integrates with national nutrition and other appropriate programmes to help reduce NCD risk factors in the general population, making clear the roles of different sectors, stakeholders, NGOs and all partners.
2. Establish national physical activity guidelines that would suit different sectors of the population and which are sensitive to the community's cultural and social values.
3. Develop a national physical activity plan. This should have attainable targets and a time-line for specific interventions, and should include all sections of the population.
4. Integrate coordination of physical activity into an appropriate existing national body specifically for physical activity or develop one if there is none.

5. Establish national social marketing strategies to advocate the physical activity policy and plan to policy-makers, stakeholders, community and the general population.
6. Establish a strategy for marketing a sustainable physical activity plan to possible local and overseas donors and source funds for physical activity from diverse organizations.
7. Establish a comprehensive and comparable national monitoring, evaluation and information dissemination system on physical activity if there is none, or integrate it into an existing system.
8. Review existing national laws, and if there are none relevant to health protection, develop a bill that would include physical activity as a component, making provisions for direct or indirect incentives (such as tax-free status for gymnasias and fitness centres).
9. Work with local government to establish more venues and facilities for physical activity and to coordinate action by different sectors.

To WHO

1. Stimulate and facilitate the provision of information and advice, funds and technical resources with United Nations agencies and other international and national partners.
2. Help identify sources of funds for sports equipment such as footballs, volleyball nets, etc.
3. Provide support to implementation of pilot projects and standards in each environmental initiative to promote physical activity.
4. Discuss roles for the private sector, including sponsorship, and facilitate the collaboration of government, private sector and NGOs.

Promoting healthy diets and active lifestyles in specific settings

To Member States:

SCHOOLS

1. Ensure the existence of, and /or strengthen the food, nutrition and physical activity curriculum in schools.
2. Ensure that the school curriculum promotes traditional food culture and skills for preparation of healthy food, extended to all children.
3. Ensure that schools provide physical activity options that are culturally suitable for both boys and girls, for example traditional dances and martial arts.
4. Ensure that teachers are adequately trained and well resourced for teaching nutrition and physical activity.
5. Ensure that schools allocate a minimum level of physical activity (one hour daily).
6. Ensure that there is a healthy eating policy in schools that includes contract agreements with food providers to promote availability of healthy choices.
7. Any food or drink sold in schools should meet minimum standards of food safety and nutritional value.
8. Ban the sale of food and drinks in schools exceeding the approved sugar, fat and salt level.
9. Ensure that there is no advertising or promotion of foods containing undesirable levels of fat, salt or sugar and carbonated sugary drinks targeting children in general, especially within the school environment.
10. Design schools to include playgrounds and facilities for physical activity.
11. Ensure safe walking and cycle access to schools.
12. Parents and schools should work with community groups to ensure availability of healthy food, safe water and physical activity opportunities.
13. Use schools as an avenue for nutrition and physical activity education for parents.

WORKPLACES

14. Implement a food and nutrition policy that ensures provision of healthy food at functions and receptions and in canteens.
15. In places where there is no alternative to foods other than those provided at worksites provision of healthy food choices should be mandatory.
16. In recognition of the progression from physically intensive work to desk-bound work, it is essential for workers' health and productivity to insure a minimum level of physical activity as part of work scheduling.
17. Explore incentives to increase participation in physical activity, for example, through subsidizing club memberships and supporting active transport such as walking, or cycling.
18. Promote incidental physical activity such as taking the stairs or walking to talk to someone.
19. Establish a committee with representation from senior management to promote healthy diets and physical activity.
20. Explore ways for voluntary health promotion initiatives to become occupational health and safety requirements.

LOCAL GOVERNMENT/URBAN PLANNERS

21. Ensure the provision of safe and accessible cycling and walk pathways.
22. Provide subsidies to reduce the cost of using public physical activity facilities.
23. Determine, through licensing of food outlets, what types of food are sold in the vicinity of schools and within health care institutions.
24. Make health impact assessment an integral policy requirement for major planning and development processes at the local level.

TRANSPORT

25. Foster cooperation with transport agencies to prioritize walking, cycling, and taking public transport.

MEDIA

26. Build cooperation with media using public relations to achieve coverage of nutrition and physical activity issues.
27. Use media for social marketing campaigns and strategies.
28. Consider restricting advertising of foods containing undesirable levels of fat, salt and sugar, carbonated sugary drinks, confectionaries and slimming aids.

To WHO

1. WHO should continue to support the planning, implementation and evaluation of interventions through the "healthy settings" approach, with special emphasis on schools, as a particularly important environment for promoting healthy diets and lifestyles

Plans and processes for a regional NCD network

To Member States

1. Source cross-sectoral collaborators for the network such as NGOs, donor agencies, selected commercial entities and research units.
2. Establish resources for setting up and sustaining MOANA (such as national funds, national capacities to be shared with other members).

To WHO

1. Draft a white paper for consultation and submission to Member States and other stakeholders for their commentary and review. Develop a final version of the mission, objective, and structure of MOANA.
2. Organize a regional network meeting (in May 2004) to launch the network officially.

3. Establish the MOANA protocol, a framework for planning, implementing, evaluating and sharing integrated approaches to NCD prevention and control.
4. Initiate and pilot a web-based networking facility.
5. Propose projects for outcome evaluation and develop a best practice database.
6. Propose priority areas for standard and framework development.
7. Foster the contribution of relevant collaborating centres to the network.
8. Provide technical expertise and other support in implementation and evaluation of demonstration projects and national NCD plans.

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